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Notice of Independent Review Decision

DATE OF REVIEW: February 27, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient stay for cervical arthrodesis anterior interbody, including disc space preparation, discectomy, osteophyctomy and decompression, cervical below C2 each additional interspace; allograft for spine, structural, anterior instrumentation of four to seven vertebral segments (22551, 22552, 20931 and 22846).

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

M.D., Board Certified in Orthopedic Surgery.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- ☒ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part/Disagree in part)

The requested inpatient stay for cervical arthrodesis anterior interbody, including disc space preparation, discectomy, osteophyctomy and decompression, cervical below C2 each additional interspace; allograft for spine, structural, anterior instrumentation of four to seven vertebral segments at Scott & White Round Rock Hospital (22551, 22552, 20931 and 22846) is not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported a work-related injury on xx/xx/xx while climbing up a ladder. The patient was noted to undergo physical therapy and two epidural steroid injections. The patient underwent magnetic resonance imaging (MRI) of the lumbar spine without contrast on

8/8/14 which revealed cervical spondylosis resulting in flattening of the cord at C3-4 and C4-5 levels and multilevel neural foraminal narrowing up to a severe degree. At the level of C3-4, there was a broad-based disc bulge, asymmetric to the left, with facet joint osteoarthritis and uncinat process hypertrophy, greater on the left. There was moderate left neural foraminal narrowing. There was contact of the cord resulting in mild flattening of the cord to the left of midline. At the level of C4-5, there was a broad based disc bulge with superimposed left paracentral disc protrusion which contacts and results in moderate flattening of the cord of the left of midline. At C4-5 and C5-6, there were anterior osteophytes. There was mild to moderate degenerative disease from C4 through C7. There was facet joint osteoarthritis and uncinat process hypertrophy resulting in moderate to severe right and moderate left neural foraminal narrowing. The progress note dated 11/16/14 revealed the patient had back pain and bilateral upper extremity radicular symptoms with right being worse than the left. The patient rated the pain as an 8/10 on the pain scale. The sensibility was noted to be intact to light touch and motor in the distribution of the radial, ulnar and median nerves of the hand. The diagnoses included cervical spondylosis with multilevel foraminal stenosis and bilateral upper extremity radiculopathy and neck pain secondary to spondylosis. The treatment plan included a possible multilevel anterior cervical discectomy and fusion from C4 through C7 to alleviate the foraminal stenosis. The patient underwent an electromyography (EMG) on 1/20/15 which revealed the patient had chronic bilateral C6 radiculopathy.

The URA denial letter dated 1/27/15 indicates that there is no evidence of instability in the cervical spine in accordance with the Official Disability Guidelines as well as lack of objective focal neurologic deficits and no psychological screening.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The Official Disability Guidelines (ODG) for cervical fusion indicate that a fusion is recommended as an option in combination with an anterior cervical discectomy for approved indications and to support the need for a fusion. Guidelines further indicate there should be documentation of spondylotic radiculopathy or non-traumatic instability with all of the following criteria. The criteria includes significant symptoms that correlate with physical examination findings and radiologist interpreted imaging reports, persistent and progressive radicular pain or weakness secondary to nerve root compression or moderate to severe neck pain despite eight weeks of conservative therapy with at least two of the following: active pain management with pharmacotherapy that address neuropathic pain and other sources, medical management with oral steroids or epidural injections and physical therapy, documented participation in a formal active physical therapy program, clinically significant functional limitation resulting in inability or significantly decreased ability to perform normal daily activities of work or home duties and diagnostic imaging demonstrating cervical nerve root compression. The decision on technique including autograft versus allograft instrumentation is left to the surgeon. A discectomy is recommended when there is evidence of radicular pain and sensory symptoms in a cervical distribution correlating with the involved cervical level or the presence of a positive Spurling's test. There should be evidence of a motor deficit or reflex change or positive electromyography (EMG) findings correlating with the cervical level. There should be documentation of abnormal

imaging correlating with nerve root involvement. Finally, there should be documentation the patient has failed at least six to eight weeks of a trial of conservative care.

In this case, the clinical documentation submitted for review does not meet the guideline recommendations. The documentation indicates that the patient had participated in therapy and had two epidural steroid injections without significant relief. However, there was no documentation of the duration of conservative therapy. There was no documentation of radiculopathy at all the requested levels. The patient had radiculopathy at C6 by EMG, however the MRI of the lumbar spine failed to indicate the patient had findings of nerve impingement to support the need for a discectomy. There were no x-rays demonstrating instability on flexion and extension. The physical examination failed to provide documentation of radiculopathy upon examination, as his sensibility was noted to be intact. As such, the requested services are not medically necessary for treatment of the patient's condition. All told, the medical necessity for inpatient stay for cervical arthrodesis anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression, cervical below C2 each additional interspace; allograft for spine, structural, anterior instrumentation of four to seven vertebral segments at Scott & White Round Rock Hospital (22551, 22552, 20931 and 22846) has not been established. Based on the clinical information received and the ODG guidelines, the current request cannot be determined as medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- ☐ MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)